



## STATE OF ILLINOIS

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Facility Name & ID Number St Martha Manor# 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>75</u>	Intermediate (ICF)	<u>75</u>	<u>27,450</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>132</u>	TOTALS	<u>132</u>	<u>48,312</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,033</u>			<u>3,033</u>	8
9	SNF/PED					9
10	ICF	<u>42,550</u>	<u>44</u>		<u>42,594</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>45,583</u>	<u>44</u>		<u>45,627</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 94.44%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/1978

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/1978 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

St Martha Manor

# 0023770

Report Period Beginning:

01/01/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	202,600	25,859	28,331	256,790		256,790		256,790		1
2	Food Purchase		376,244		376,244	(34,631)	341,613	(4)	341,609		2
3	Housekeeping	107,153	39,777	158,463	305,393		305,393		305,393		3
4	Laundry		28,868		28,868		28,868		28,868		4
5	Heat and Other Utilities			126,216	126,216		126,216	1,026	127,242		5
6	Maintenance	102,070		97,957	200,027		200,027	(21,628)	178,399		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	411,823	470,748	410,967	1,293,538	(34,631)	1,258,907	(20,606)	1,238,301		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	991,991	144,759	631,757	1,768,507		1,768,507		1,768,507		10
10a	Therapy			7,089	7,089		7,089		7,089		10a
11	Activities	24,076	14,624	140,517	179,217		179,217		179,217		11
12	Social Services	125,020		28,072	153,092		153,092		153,092		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,141,087	159,383	808,635	2,109,105		2,109,105		2,109,105		16
	<b>C. General Administration</b>										
17	Administrative			511,000	511,000		511,000	(359,546)	151,454		17
18	Directors Fees										18
19	Professional Services			42,662	42,662	(21,162)	21,500	4,850	26,350		19
20	Dues, Fees, Subscriptions & Promotions			13,232	13,232		13,232	(3,044)	10,188		20
21	Clerical & General Office Expenses	55,234	35,844	65,797	156,875		156,875	43,197	200,072		21
22	Employee Benefits & Payroll Taxes			246,422	246,422	34,631	281,053		281,053		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,015	1,015		1,015	41	1,056		24
25	Other Admin. Staff Transportation			176	176		176	2,688	2,864		25
26	Insurance-Prop.Liab.Malpractice			104,598	104,598		104,598	4,366	108,964		26
27	Other (specify):*							44,837	44,837		27
28	<b>TOTAL General Administration</b>	55,234	35,844	984,902	1,075,980	13,469	1,089,449	(262,611)	826,838		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,608,144	665,975	2,204,504	4,478,623	(21,162)	4,457,461	(283,217)	4,174,244		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number St Martha Manor

#0023770

Report Period Beginning:

01/01/04

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			85,321	85,321		85,321	(15,915)	69,406			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			612	612		612	71,527	72,139			32
33	Real Estate Taxes			85,629	85,629	21,162	106,791	14,185	120,976			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			12,045	12,045		12,045		12,045			35
36	Other (specify):*							11,571	11,571			36
37	<b>TOTAL Ownership</b>			363,607	363,607	21,162	384,769	(98,632)	286,137			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			50,980	50,980		50,980	(3,659)	47,321			41
42	Provider Participation Fee			72,468	72,468		72,468		72,468			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			123,448	123,448		123,448	(3,659)	119,789			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,608,144	665,975	2,691,559	4,965,678		4,965,678	(385,508)	4,580,170			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Martha Manor

# 0023770

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,992)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,911)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(490)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(75,221)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (97,818)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(287,690)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (287,690)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (385,508)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
St Martha Manor			
Id#	0023770		
Report Period Beginning:	01/01/04		
Ending:	12/31/04		
NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
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66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101			101
Total	(75,221)		

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number St Martha Manor

# 0023770

Report Period Beginning:

01/01/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(4)											(4)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			992		34							1,026	5
6	Maintenance	(24,630)		3,002									(21,628)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(24,634)</b>		<b>3,994</b>		<b>34</b>							<b>(20,606)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													16
	<b>C. General Administration</b>													
17	Administrative			(493,723)	63,504	70,673							(359,546)	17
18	Directors Fees													18
19	Professional Services	(931)		5,781									4,850	19
20	Fees, Subscriptions & Promotions	(4,111)		1,067									(3,044)	20
21	Clerical & General Office Expenses	(45,016)		88,213									43,197	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			41									41	24
25	Other Admin. Staff Transportation			2,688									2,688	25
26	Insurance-Prop.Liab.Malpractice			4,366									4,366	26
27	Other (specify):*			20,690	9,479	14,668							44,837	27
28	<b>TOTAL General Administration</b>	<b>(50,058)</b>		<b>(370,877)</b>	<b>72,983</b>	<b>85,341</b>							<b>(262,611)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(74,692)</b>		<b>(366,883)</b>	<b>72,983</b>	<b>85,375</b>							<b>(283,217)</b>	<b>29</b>





Facility Name & ID Number St Martha Manor# 0023770

Report Period Beginning:

01/01/04

Ending:

12/31/04

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peter O'Brien	60.00%	See Attached		See Attached		
Daniel O'Brien	20.00%					
Mary O'Brien	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 180,000	Property Account 4621	100.00%	\$ 180,000	\$ (180,000)	1
2	V	17 Management Fee	96,000	Property Account 4621	100.00%	96,000		2
3	V	36 Amortization		Property Account 4621	100.00%	1,711	1,711	3
4	V	32 Interest		Property Account 4621	100.00%	56,070	56,070	4
5	V	36 Other		Property Account 4621	100.00%	9,860	9,860	5
6	V	33 Real Estate Taxes		Property Account 4621	100.00%	9,577	9,577	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 276,000			\$ 173,218	\$ * (102,782)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **St Martha Manor**# **0023770**Report Period Beginning: **01/01/04**Ending: **12/31/04****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 992	\$ 992	15
16	V	6 REPAIRS AND MAINT.				3,002	3,002	16
17	V	17 ADMINISTRATIVE				17,277	17,277	17
18	V	19 PROFESSIONAL FEES				5,781	5,781	18
19	V	20 DUES AND SUBSCRIPTIONS				1,067	1,067	19
20	V	21 CLERICAL AND GENERAL				88,213	88,213	20
21	V	24 SEMINARS				41	41	21
22	V	25 AUTO EXPENSE				2,688	2,688	22
23	V	26 PROPERTY INSURANCE				4,366	4,366	23
24	V	27 GEN. ADMIN. - EMP. BEN.				20,690	20,690	24
25	V	30 DEPRECIATION				3,336	3,336	25
26	V	32 INTEREST				15,457	15,457	26
27	V	33 REAL ESTATE TAXES				2,426	2,426	27
28	V							28
29	V	17 MANAGEMENT FEES	511,000				(511,000)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 511,000			\$ 165,336	\$ * (345,664)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 SALARY-D. O'BRIEN	\$	MADO MGMT. LP	100.00%	\$ 31,752	\$ 31,752
16	V	27 EMP. BEN.-D. O'BRIEN				4,504	4,504
17	V						
18	V	17 SALARY-P. O'BRIEN				31,752	31,752
19	V	27 EMP. BEN.-P. O'BRIEN				4,975	4,975
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 72,983	\$ * 72,983

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 34	\$ 34	15
16	V	6 REPAIRS AND MAINTENANCE						16
17	V	10 NURSING SALARY						17
18	V	15 HEALTH CARE - EMP. BEN.						18
19	V	17 ADMINISTRATIVE SALARY				70,673	70,673	19
20	V	21 CLERICAL SALARY						20
21	V	27 GEN. ADMIN. - EMP. BEN.				14,668	14,668	21
22	V	30 DEPRECIATION-WAREHOUSE				216	216	22
23	V	33 REAL ESTATE TAXES				2,182	2,182	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 87,773	\$ * 87,773	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 22,126	Windy City Nursing	100.00%	\$ 22,126	\$
16	V	3 Housekeeping	112,148	Windy City Nursing	100.00%	112,148	
17	V	6 Maintenance	9,474	Windy City Nursing	100.00%	9,474	
18	V	11 Activities	25,680	Windy City Nursing	100.00%	25,680	
19	V	12 Social Services	18,146	Windy City Nursing	100.00%	18,146	
20	V	21 Office	65,738	Windy City Nursing	100.00%	65,738	
21	V	10 Nursing	357,434	Windy City Nursing	100.00%	357,434	
22	V	4 Laundry	46,316	Windy City Nursing	100.00%	46,316	
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 657,062			\$ 657,062	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Supplies	\$ 19,147	St. Agnes Medical Equipment	100.00%	\$ 19,147	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 19,147			\$ 19,147	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel O'Brien	Owner	Administrative	20.00%	See Attached	4.50	11.25%	Allocated	\$ 31,752	17-7	1
2	Peter O'Brien	Owner	Administrative	60.00%	See Attached	8.60	14.33%	Allocated	31,752	17-7	2
3	Bridget Stumpf	Administrator	Administrative	0	none	40.00	100.00%	Allocated	70,673	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 134,177		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization MADO MGMT. LP  
 Street Address 1541 N. WELLS ST.  
 City / State / Zip Code CHICAGO, IL. 60610  
 Phone Number ( 312) 787-9400  
 Fax Number ( 312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	244,284	5	\$ 5,309	\$	45,627	\$ 992	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	244,284	5	16,071		45,627	3,002	2
3	17 ADMINISTRATIVE	PATIENT DAYS	244,284	5	92,500	92,500	45,627	17,277	3
4	19 PROFESSIONAL FEES	PATIENT DAYS	244,284	5	30,950		45,627	5,781	4
5	20 DUES AND SUBSCRIPTIONS	PATIENT DAYS	244,284	5	5,714		45,627	1,067	5
6	21 CLERICAL AND GENERAL	PATIENT DAYS	244,284	5	472,288	406,985	45,627	88,213	6
7	24 SEMINARS	PATIENT DAYS	244,284	5	221		45,627	41	7
8	25 AUTO EXPENSE	PATIENT DAYS	244,284	5	14,390		45,627	2,688	8
9	26 PROPERTY INSURANCE	PATIENT DAYS	244,284	5	23,374		45,627	4,366	9
10	27 GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	244,284	5	110,773		45,627	20,690	10
11	30 DEPRECIATION	PATIENT DAYS	244,284	5	17,861		45,627	3,336	11
12	32 INTEREST	PATIENT DAYS	244,284	5	82,756		45,627	15,457	12
13	33 REAL ESTATE TAXES	PATIENT DAYS	244,284	5	12,989		45,627	2,426	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 885,196	\$ 499,485		\$ 165,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization MADO MGMT. LP  
 Street Address 1541 N. WELLS ST.  
 City / State / Zip Code CHICAGO, IL. 60610  
 Phone Number ( 312) 787-9400  
 Fax Number ( 312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	170,000	170,000	4	31,752	1
2	27 EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	24,116		4	4,504	2
3									3
4	17 SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	5	170,000	170,000	9	31,752	4
5	27 EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	5	26,636		9	4,975	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 390,752	\$ 340,000		\$ 72,983	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770 Report Period Beginning: 01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization MADO MGMT. LPStreet Address 1541 N. WELLS ST.City / State / Zip Code CHICAGO, IL. 60610Phone Number ( 312) 787-9400Fax Number ( 312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	DIRECT ALLOCATION		1	34			34	1
2	6 REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1					2
3	10 NURSING SALARY	DIRECT ALLOCATION		2	56,592	56,592			3
4	15 HEALTH CARE - EMP. BEN.	DIRECT ALLOCATION		2	10,551				4
5	17 ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	292,744	292,744		70,673	5
6	21 CLERICAL SALARY	DIRECT ALLOCATION		2	55,306	55,306			6
7	27 GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	70,268			14,668	7
8	30 DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	216			216	8
9	33 REAL ESTATE TAXES	DIRECT ALLOCATION		1	2,182			2,182	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 487,893	\$ 404,642		\$ 87,773	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor# 0023770

Report Period Beginning:

01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Windy City NursingStreet Address 1541 N. WellsCity / State / Zip Code Chicago, IL 60610Phone Number (312) 787-9400Fax Number (312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u> <u>Dietary</u>	<u>DIRECT ALLOCATION</u>			\$	\$		\$ 22,126	1
2	<u>3</u> <u>Housekeeping</u>	<u>DIRECT ALLOCATION</u>						112,148	2
3	<u>6</u> <u>Maintenance</u>	<u>DIRECT ALLOCATION</u>						9,474	3
4	<u>11</u> <u>Activities</u>	<u>DIRECT ALLOCATION</u>						25,680	4
5	<u>12</u> <u>Social Services</u>	<u>DIRECT ALLOCATION</u>						18,146	5
6	<u>21</u> <u>Office</u>	<u>DIRECT ALLOCATION</u>						65,738	6
7	<u>10</u> <u>Nursing</u>	<u>DIRECT ALLOCATION</u>						357,434	7
8	<u>4</u> <u>Laundry</u>	<u>DIRECT ALLOCATION</u>						46,316	8
9		<u>DIRECT ALLOCATION</u>							9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 657,062	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization St. Agnes Medical Equipment  
 Street Address 1541 N. Wells  
 City / State / Zip Code Chicago, IL 60610  
 Phone Number ( 312) 787-9400  
 Fax Number ( 312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies	Direct Allocation		\$	\$		\$ 19,147	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 19,147	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor # 0023770 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	4621 Building Corporation		X	Mortgage	\$16,355.00	12/28/98	\$ 1,100,000	\$ 919,010	12/31/08		\$ 56,070	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	TIFCO		X	Insurance Financing							612	6	
7	Allocated - MADO		X								15,457	7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$16,355.00		\$ 1,100,000	\$ 919,010			\$ 72,139	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,100,000	\$ 919,010			\$ 72,139	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- \* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- \*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **St Martha Manor**# **0023770** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	<b>112,302</b> 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>102,106</b> 2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(10,196)</b> 3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>110,009</b> 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>21,162</b> 5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>120,975</b> 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	<b>99,879</b>	8	
	2000	<b>99,209</b>	9	
	2001	<b>92,929</b>	10	
	2002	<b>100,764</b>	11	
	2003	<b>97,498</b>	12	
<b>Accrual = \$104,771 X 1.05</b>				
<b>Allocated from MADO Management - \$4,608</b>				
				13 FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME St Martha Manor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023770

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-207-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>86,178.66</u>	\$ <u>86,178.66</u>
2. <u>14-17-207-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,742.70</u>	\$ <u>1,742.70</u>
3. <u>14-17-207-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,293.25</u>	\$ <u>3,293.25</u>
4. <u>14-17-207-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,272.31</u>	\$ <u>7,272.31</u>
5. <u>14-17-207-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,283.69</u>	\$ <u>6,283.69</u>
6. <u>17-04-204-012-0000</u>	<u>Home Office (See Attached)</u>	\$ <u>19,779.74</u>	\$ <u>2,512.21</u>
7. <u>14-17-207-014-0000</u>	<u>Home Office (See Attached)</u>	\$ <u>7,272.31</u>	\$ <u>2,181.69</u>
8. <u>14-17-207-014-0000</u>	<u>Bill Counted Twice</u>	\$ <u>(7,272.31)</u>	\$ <u>(7,272.31)</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>124,550.35</u></u>	\$ <u><u>102,192.20</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X   YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	<u>St Martha Manor</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0023770</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE (847)236-1111		FAX #:	(847)236-1155

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 **35,364**

B. General Construction Type:
 Exterior
 Frame
 **Fire Retardant**

Number of Stories
 **6**

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	12,868	1984	\$ 70,700	1
2					2
3	TOTALS	12,868		\$ 70,700	3

Facility Name &amp; ID Number St Martha Manor

# 0023770

Report Period Beginning:

01/01/04

Ending:

12/31/04

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Various	1978	541		20	-		541	9
10	Various	1979	38,105		20	-		38,105	10
11	Various	1981	22,244		20	-		22,244	11
12	Various	1982	12,527		20	-		12,527	12
13	Various	1983	5,530		20	-		5,530	13
14	Various	1984	25,958		20	-		25,958	14
15	Various	1985	10,641		20	-		10,641	15
16	Various	1986	13,635		20	682	682	8,183	16
17	Various	1987	65,231		20	-		65,231	17
18	Various	1988	30,395		20	(140)	(140)	29,975	18
19	Various	1990	115,949		20	5,107	5,107	87,355	19
20	Various	1991	10,000		20	500	500	4,162	20
21	Various	1992	22,069		20	1,104	1,104	20,370	21
22	Various	1993	18,217		20	883	883	13,809	22
23	Various	1994	12,220		20	611	611	6,721	23
24	Various	1995	109,219		20	5,355	5,355	58,520	24
25	Various	1996	28,361		20	1,418	1,418	12,481	25
26	Various	1997	69,848		20	3,759	3,759	28,540	26
27	Various	1998	56,951		20	2,851	2,851	18,567	27
28	Various	1999	93,038		20	4,651	4,651	25,853	28
29	Various	2000	84,672		20	4,236	4,236	18,940	29
30						-		-	30
31						-		-	31
32						-		-	32
33						-		-	33
34						-		-	34
35						-		-	35
36						-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,494,824					1,494,824	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		80,943	2,211		2,804	593	25,418	68
69	Financial Statement Depreciation			83,846			(83,846)		69
70	TOTAL (lines 4 thru 69)		\$ 2,421,118	\$ 86,057		\$ 33,821	\$ (52,236)	\$ 2,034,495	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,584,078	\$ 86,057		\$ 46,500	\$ (39,557)	\$ 2,069,770	1
2	Gutter Repairs	2002	5,400		20	540	540	1,485	2
3	Windows	2002	1,836		20	184	184	505	3
4	Concrete Work	2002	1,600		20	160	160	453	4
5	Elevator Repairs	2002	1,054		20	105	105	281	5
6	Ac Repairs	2002	2,705		20	225	225	582	6
7	Tuckpointing	2002	10,000		20	1,000	1,000	2,417	7
8	Office Renovations	2002	942		20	94	94	236	8
9	Sprinkler Repairs	2002	930		20	93	93	225	9
10	Awning Repairs	2002	650		20	65	65	152	10
11	Tuckpointing	2002	1,800		20	180	180	405	11
12	Heat Exchanger	2002	2,595		20	260	260	584	12
13	Elevator Repairs	2002	924		20	46	46	104	13
14	Bathroom Repairs	2002	686		20	69	69	154	14
15	Cubicle Curtains	2003	1,644		20	82	82	164	15
16	Stainless Steel For Kitchen'	2003	1,620		20	81	81	162	16
17	New Kitchen Project	2003	3,106		20	155	155	285	17
18	Fire Escape Repairs	2003	690		20	35	35	60	18
19	Exit Door Renovation	2003	1,954		20	98	98	171	19
20	Block Reinforcement Install	2003	1,250		20	63	63	109	20
21	Brick Wall Replacement	2003	1,350		20	68	68	113	21
22	Metal Door	2003	1,878		20	94	94	149	22
23	Fire Door Closer	2003	682		20	34	34	54	23
24	Stainless Steel For Kitchen	2003	716		20	36	36	66	24
25	Refrigeration System	2003	20,888		20	1,044	1,044	1,567	25
26	Kitchen Roof Repairs	2003	2,500		20	125	125	156	26
27	Vertical Blinds	2003	1,087		20	54	54	68	27
28	Garage Door Installation	2003	2,200		20	110	110	128	28
29	Sprinkler Repairs	2003	764		20	38	38	76	29
30	Fire Alarm Repairs	2003	593		20	30	30	54	30
31	Valve Repairs	2003	590		20	30	30	49	31
32	Smoke Detectors	2003	600		20	30	30	50	32
33	Landscaping	2003	1,925		20	96	96	160	33
34	TOTAL (lines 1 thru 33)		\$ 2,661,237	\$ 86,057		\$ 51,824	\$ (34,233)	\$ 2,080,994	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12D

Facility Name &amp; ID Number St Martha Manor

# 0023770

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,661,237	\$ 86,057		\$ 51,824	\$ (34,233)	\$ 2,080,994	1
2	Auxillary Power Repairs	2003	710		20	36	36	47	2
3	Elevator Repairs	2003	1,173		20	59	59	108	3
4	Elevator Repairs	2003	1,038		20	52	52	91	4
5	Door Closer	2003	697		20	35	35	46	5
6	Roof Repairs	2003	2,000		20	100	100	125	6
7	Dining Rm/Lobby/Elev Repairs	2003	10,592		20	530	530	662	7
8	New Wood Door/Hinges/Butts& Lock	2004	2,279		20	209	209	209	8
9	Wrought Iron Fence	2004	1,200		20	110	110	110	9
10	Metal Doors For Fire Exits	2004	942		20	79	79	79	10
11	Metal Doors For Kitchen And Med Room	2004	2,124		20	177	177	177	11
12	Built Brick Walls	2004	1,300		20	108	108	108	12
13	Bricking Up 2 Window Openings	2004	750		20	63	63	63	13
14	Sidewall Sprinkler Heads	2004	2,157		20	180	180	180	14
15	Counter Fire Door	2004	39,400		20	2,627	2,627	2,627	15
16	Panic Bars/Mesh Wire Per City Code	2004	2,240		20	93	93	93	16
17	Hand Recognition Time Clock	2004	5,621		20	187	187	187	17
18	Fire Alarm	2004	16,298		20	1,222	1,222	1,222	18
19	Alarm Relay	2004	1,200		20	70	70	70	19
20	Smoke Detectors	2004	1,400		20	70	70	70	20
21	Repair Boiler In Mech. Room	2004	945		20	95	95	95	21
22	Door Glass	2004	650		20	65	65	65	22
23	Conduit And Connectors	2004	1,418		20	142	142	142	23
24	Auto Air Vent, 1/2 Release Valve	2004	1,178		20	118	118	118	24
25	Rinse Guard System	2004	1,798		20	180	180	180	25
26	Jockey Pump	2004	2,430		20	243	243	243	26
27	Fire Alarm Motherboard	2004	1,820		20	182	182	182	27
28	Hardware For Room Repairs	2004	748		20	75	75	75	28
29	Paint For Room Repairs	2004	2,668		20	267	267	267	29
30	Boiler Pump And Motor Assmbly	2004	1,516		20	152	152	152	30
31	Repair Water Line	2004	5,800		20	580	580	580	31
32	Condensing Motor Fan	2004	723		20	72	72	72	32
33	Tuckpointing And Rebuild Lndry Rm	2004	850		20	85	85	85	33
34	TOTAL (lines 1 thru 33)		\$ 2,776,902	\$ 86,057		\$ 60,085	\$ (25,972)	\$ 2,089,522	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,776,902	\$ 86,057		\$ 60,085	\$ (25,972)	\$ 2,089,522	1
2	Motor On Steam Line	2004	1,540		20	154	154	154	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12E, Carried Forward		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward	\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward	\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
Constructed			Depreciation	in Years	Depreciation		Depreciation	
1	Totals from Page 12J, Carried Forward	\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,778,442	\$ 86,057		\$ 60,239	\$ (25,818)	\$ 2,089,676	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1984		\$ 1,494,824	\$		\$	\$	\$ 1,494,824	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 1,494,824	\$		\$	\$	\$ 1,494,824		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	MADO		1985		\$ 21,630	\$ 216	35	\$ 618	\$ 402	\$ 5,562
5	MADO		1988		38,714	1,408	35	1,106	(302)	9,955
6										
7										
8										
Improvement Type**										
9	Allocated from MADO Management		1993		14,746	393	20	737	344	8,423
10			1995		898	179	20	45	(134)	427
11			2000		2,205	-	20	110	110	499
12			2001		955	15	20	48	(33)	178
13			2002		1,503	-	20	136	136	370
14			2002		292	-	20	4	4	4
15										
16										
17										
18										
19										
20										
21										
22										
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27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 80,943	\$ 2,211		\$ 2,804	\$ 527	\$ 25,418	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 125,725	\$ 1,342	\$ 8,847	\$ 7,505	10	\$ 90,146	71
72	Current Year Purchases	3,256		321	321	10	321	72
73	Fully Depreciated Assets	170,746				10	170,746	73
74								74
75	TOTALS	\$ 299,727	\$ 1,342	\$ 9,168	\$ 7,826		\$ 261,213	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1988 MERCEDES	1988	\$	\$	\$			\$	76
77		BMW	1998	25,000				5	25,000	77
78		BMW	1998							78
79										79
80	TOTALS			\$ 25,000	\$	\$	\$		\$ 25,000	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,173,869	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,399	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,407	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,992)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,375,889	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1988 MERCEDES - 1988	\$ 54,359	\$ 1,475	\$	86
87	BMW - 1998	18,000			87
88					88
89					89
90					90
91	TOTALS	\$ 72,359	\$ 1,475	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                      \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 12,046

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 524	\$ 1,254	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	784,150	799,381	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,198	32,198	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,148,750	4,491,462	8
9	Other(specify): <a href="#">See Attached Schedule</a>	7,846	7,846	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,973,468	\$ 5,332,141	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		70,700	14
15	Leasehold Improvements, at Historical Cost	1,062,433	2,557,257	15
16	Equipment, at Historical Cost	425,479	425,479	16
17	Accumulated Depreciation (book methods)	(955,350)	(2,450,174)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		17,111	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,266)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	3,100	3,100	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 535,662	\$ 613,207	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,509,130	\$ 5,945,348	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 180,154	\$ 787,154	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,215	23,215	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,009	110,009	32
33	Accrued Interest Payable		9,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	1,342,712	1,342,712	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,656,090	\$ 2,272,090	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		919,010	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 919,010	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,656,090	\$ 3,191,100	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,853,040	\$ 2,754,248	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,509,130	\$ 5,945,348	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 3,115,341</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Restatement - See Attached</b>	<b>(99,490)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 3,015,851</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(162,811)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (162,811)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 2,853,040</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	1	2	3
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,799,208	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,799,208	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,659	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,659	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,802,867	30

	2	3	4
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,293,538	31
32	Health Care	2,109,105	32
33	General Administration	1,075,980	33
	<b>B. Capital Expense</b>		
34	Ownership	363,607	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	50,980	35
36	Provider Participation Fee	72,468	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,965,678	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(162,811)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (162,811)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number St Martha Manor# 0023770Report Period Beginning: 01/01/04Ending: 12/31/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,879	8,631	193,651	22.44	3
4	Licensed Practical Nurses	10,544	11,409	204,447	17.92	4
5	Nurse Aides & Orderlies	58,880	62,829	567,473	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,078	2,207	24,076	10.91	9
10	Activity Assistants					10
11	Social Service Workers	14,590	15,413	125,020	8.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	710	907	12,627	13.92	14
15	Cook Helpers/Assistants	23,782	25,338	189,973	7.50	15
16	Dishwashers					16
17	Maintenance Workers	11,643	12,258	102,070	8.33	17
18	Housekeepers	12,528	13,561	107,153	7.90	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,089	3,143	55,234	17.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,132	2,418	26,420	10.93	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	147,855	158,114	\$ 1,608,144 *	\$ 10.17	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	206	\$ 6,205	01-03	35
36	Medical Director	Monthly	1,200	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	169	7,089	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,912	11-03	44
45	Social Service Consultant	179	9,926	12-03	45
46	Other(specify) <u>Soc Srv Outside Lbr</u>	1,235	18,146	12-03	46
47	<u>Activity Outside Labor</u>	19,253	138,605	11-03	47
48	<u>Dietary Outside Labor</u>	1,360	22,126	01-03	48
49	TOTAL (lines 35 - 48)	22,438	\$ 209,337		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	18,322	\$ 500,619	10-03	50
51	Licensed Practical Nurses	5,899	123,787	10-03	51
52	Nurse Aides	370	3,223	10-03	52
53	TOTAL (lines 50 - 52)	24,591	\$ 627,629		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance		\$ 31,419	IDPH License Fee	\$ 1,050
				Unemployment Compensation Insurance		22,484	Advertising: Employee Recruitment	5,890
				FICA Taxes		122,670	Health Care Worker Background Check (Indicate # of checks performed <u>50</u> )	640
				Employee Health Insurance		69,509	Licenses and Fees	1,541
				Employee Meals		34,631	Allocate MADO	1,067
				Illinois Municipal Retirement Fund (IMRF)*				
				401K - Employers Share		340		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$					
<b>B. Administrative - Other</b>								
Description			Amount					
MADO Management - Management Fee			\$ 511,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 511,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 281,053	Less: Public Relations Expense	( )
(Attach a copy of any management service agreement)							Non-allowable advertising	( )
							Yellow page advertising	( )
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
FR&R	Accounting		\$ 8,080			\$	Out-of-State Travel	\$
Wolf & Company	Accounting		5,396					
Personnel Planners	Unemployment Consult		1,194					
Maemar	Architect		1,789				In-State Travel	
Paul J. Reilly	Legal		21,162					
Neal, Gerber, Eisenberg	Legal		931					
HDSI	Data Processing		4,110				Seminar Expense	1,015
							Allocate MADO	41
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 42,662				TOTAL	\$ 1,056

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Martha Manor

STATE OF ILLINOIS

# 0023770

Report Period Beginning:

01/01/04

Ending:

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12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,874 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 72,468  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 34,631 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.